A JOURNEY TO DECREASED CHF READMISSIONS

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MERCYHEALTH
Fairfield Hospital

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

MERCY FAIRFIELD HEART FAILURE TEAM

Heart Failure Program Mission Statement:

The Mercy Heart Failure program strives to improve the quality of life for patients and their caregivers through empowerment, knowledge, spiritual support and community outreach. The process is an interdisciplinary effort to meet the variety of needs for our clients.

Team Members:

- Jennifer Bittner BSN, RN - Director of Cardiovascular services
- Jacqueline Smith BSN, RN- Nurse Manager of Telemetry, Heart Failure
- Denna Dietrich CNP- Lead Nurse practitioner
- Susan Radcliffe CNP-Nurse practitioner
- Rita Cassidy MSN, RN- Navigator
- Lynne Wagoner, MD- Regional lead physician for Heart Failure
- Gena Hoskins – Medical Assistant

OBJECTIVES

1. Establish an interdisciplinary team and approach
    1. One designated representative from pharmacy, dietary, Cardiac rehab, discharge planning, cardiology, and palliative care met biweekly to identify gaps and educational needs from each discipline's perspective.
2. Deliver extensive patient education in inpatient & outpatient setting.
3. Allow patients with similar illness an opportunity to interact.
    1. Multiple group settings were provide including group visits, support group and shared medical visits.
4. Collaborate with Primary care physicians and the primary cardiologist.
5. Ensure staff has the skills and confidence to meet the care needs of heart failure patients.
6. Empower patients and caregivers for self care.
7. Provide community outreach and education opportunities.
8. Build a collaborative care network with Home healthcare companies and extended care facilities.

INPATIENT DEVELOPMENT

Inpatient classes

- Inpatient classes for patient and their caregivers.
- Interdisciplinary approach included: pharmacy, dietary, cardiac rehab, cardiology.
- Each specialty spends 15-20 minutes teaching the class.
- Patients are provided an educational book, magnet with signs & symptoms, scale and disease management resources.

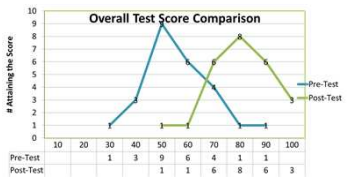
Nurse Education

- Education packets were given weekly for 3 weeks
- Packet topics included:
    - What is HF?
    - HF medications
    - Patient assessment
- Physician provided educational lecture with multiple dates for attendance.
- Yearly competencies for all nursing staff (ilearn/electronic education)
- Resource binder for each unit
- Data

Follow up appointment

- Patients are scheduled for follow-up appointments by nursing staff prior to discharge with following physician (PCP, cardiology, etc)
- If a patient is not associated with cardiology and unable to obtain a 1 week follow-up they are placed with HF NP if agreeable

Nurses were provided with a pre and post test to assess knowledge



OUTPATIENT DEVELOPMENT

Discharge Phone Calls

- WHO: Patients who participated in inpatient classes, who were seen as a consult or who deemed high risk.
- WHEN: Called within 24-48 hours after discharge.
- WHAT: Symptoms, discharge weight, medications, dietary restrictions and follow-up appointments are reviewed with the patient

Resource Line

- The number is available Monday- Friday 8 am-5 pm.
- The resource line is answered by HF navigator, NP's, MA's
- After hours and weekend emergency calls are directed to the cardiology office and routed to the physician on-call
- For inpatient needs the Navigator carries a portable phone for direct contact
- Allows RNs and providers to be more accessible to patients, families, and caregivers.

Medication access

Who Qualifies:

- Patient's must meet with financial counselor during hospitalization
- Current or future patients of shared medical visits.

What is provided:

- 30 day supply with 1 refill from hospital's outpatient pharmacy.
- Patient is discharged with their medications in hand.
- Mail order of medication while enrolled in visits and may be continued on a case-by-case basis.

Outpatient infusions

- Able to treat patient's acutely without hospitalizations.

Support Group

The support group is organized by the HF navigator and includes interdisciplinary guest speakers. Currently meets quarterly and averages 6-10 attendees

Topics include:

- Low sodium cooking demonstration
- Heart & Lung connection
- Easy Gardening
- What is CHF
- Medication management and resources

FOLLOW-UP DEVELOPMENT

Shared Medical Visits

•4 Sessions with a different educational topic each time.

- Topics include: What is Heart Failure, Dietary, Activity, Coping with a chronic illness

• Set day and time

•Patients attend biweekly and rotate through all 4 sessions

•Patient can enter at any session, will receive education on all 4 topics.

•Patient is encouraged to attend with caregiver, spouse, or friend.

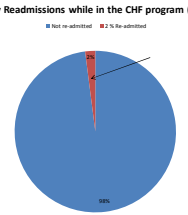
•Confidentiality is maintained throughout

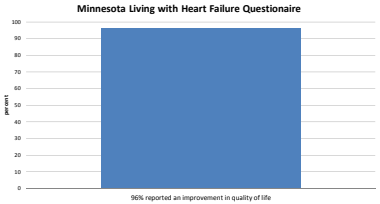
OUTCOMES

Demographics

Youngest: 32yrs Oldest: 80 yrs

Diastolic: 50% Systolic: 50%





RESPONSES FROM PATIENTS

"I liked that it was practical, gave me knowledge and more control"

"I liked talking to everybody who had the same thing as you. You can get some good ideas from them"

"Thank you so much! This program is so needed. I had a lot of fear not knowing or understanding what was happening to me or why and what my future was going to be. This eased those fears"

"Calmed my fears, answered all concerns, strong support team, helped me feel confident, great information moving forward"